The future general practitioner: out of date and running out of time

TOBY LIPMAN

SUMMARY

In the late 1960s a Royal College of General Practitioners' working party produced a job description for the 'Future General Practitioner', together with an educational programme for vocational training. Despite the perceived success of vocational training, general practice remains academically disadvantaged compared with hospital medicine. Most general practitioners (GPs) have no contact with research or academic general practice, few achieve higher degrees compared with hospital consultants, and there are few academic posts in general practice.

Junior doctors perceive general practice as offering less intrinsic job satisfaction than hospital medicine and recruitment is falling. Registrars who have completed vocational training are reluctant to commit themselves to general practice and often drift away from it. Schemes with an academic content, designed to retain doctors in general practice, have been well received but there are few career posts in academic general practice.

Primary care groups and clinical governance will radically change the nature of general practice. GPs will no longer be at the centre of the primary health care team. Primary care trusts, serving populations of 100 000 or more at multiple sites, will still employ doctors but much of the traditional GP workload will be undertaken by nurses.

Present day vocational training produces GPs without the skills that future 'community generalists' will need. Their training will be longer and their careers more structured than at present. They will use evidence-based practice routinely and be experts in information management, interpreting and managing complex diagnostic and therapeutic problems in the context of rapidly changing health technology.

Keywords: general practitioners; primary health care development; vocational training; careers.

Introduction

From achievement to uncertainty

In the decade following the publication of *The Future General Practitioner: Learning and Teaching*, which played a central role in defining the nature of modern general practice,[1] vocational training became compulsory. It emphasised the importance of good consultation skills and the balance of 'knowledge, skills and attitudes' in forming the well-rounded general practitioner (GP). General practice was a pioneer of structured post-registration education for doctors and was acknowledged as a specialty in its own right rather than a fall-back career for failed hospital doctors.

T Lipman, MRCGP, general practitioner and Northern and Yorkshire research training fellow, Westerhope Medical Group, Newcastle upon Tyne.

Submitted: 28 April 1999; Editor's response: 2 August 1999; final acceptance: 13 September 1999.

With this record of professional development to its credit, why is general practice becoming less popular as a career choice[2] with high levels of stress among GPs?[3] Although it has become conventional to blame many of the profession's troubles on the 1990 GP Contract, it appears that, for junior hospital doctors at least (from among whom GP registrars must be recruited for vocational training), the Contract is irrelevant; what matters is the balance between the 'inferior clinical content' (and, thus, intrinsic job satisfaction) of general practice and its perceived superior lifestyle.[4] If lifestyle (including pay) is also seen to be deteriorating in general practice, then maybe we should not be surprised that its attractiveness as a career is declining.

After completing vocational training, doctors who 'end up in general practice' often find themselves 'in a void', uncertain of what to do next.[5] Many become locums, or spend time abroad, gradually drifting away from a career in general practice. Recruitment difficulties have been addressed by courses designed to attract 'lost' vocationally trained doctors back to the profession[6] and by initiatives such as the London Academic Training Scheme (LATS), in which newly vocationally trained GPs combine academic and clinical practice for a year.[7]

The primary–secondary academic divide

Although most doctors in LATS were still in general practice six months after the end of the scheme, most of them wanted to stay in academic general practice. This is presently an unrealistic aspiration for most of the profession because academic general practice is a minority activity and most established GPs have little or no contact with it. In 1995, there was one paid academic post per 124 GP principals in England and Wales, compared with 36 paid academic posts per 100 consultants.[8] Moreover, whereas higher degrees (MD or PhD) are common among hospital consultants, they are rare among GPs, confined to a small group of enthusiasts and career academics. The overwhelming majority of GPs work in an academically barren environment; for some, even the main motivation for attending educational meetings is financial.[9] Initiatives such as primary care research networks[10] and the funding of research practices are attempts to overcome the primary–secondary academic divide but GPs and practices that become involved tend to be atypical.[11] Other initiatives, such as the Royal College of General Practitioners' (RCGPs') Fellowship by Assessment scheme, have similarly been taken up by only a few GPs. [12]

The founders of the RCGP in 1952 were well aware of general practice's academic impoverishment and sought to remedy it through the College by establishing vocational training and encouraging research.[13] Despite many achievements since then (the founding of university departments of general practice, the flowering of a rich literature of general practice and primary care, vocational training, the establishment of primary care research networks), only a minority of GPs are involved in academic activities or advanced professional development.

Addressing quality of care: if we don't do it someone else will

Standards of practice have been a recurrent question since the formation of the National Health Service (NHS). Irvine's warning in 1985, 'let there be no mistake, Government and society

mean what they say — they intend to sort out our standards of care in their own way unless we show more inclination and more energy to do so ourselves'[14] was part of a sustained campaign by leaders of the RCGP (the Quality of Care Initiative) to remedy perceived inadequacies in many GPs' standards of care.[15]

In the event, the Government imposed a new contract upon an unwilling profession, which came into force in 1990. At the same time, general practice fundholding was introduced. Most changes affected organisational and financial matters rather than quality of care or the professional competence of individual GPs.[16]

The 1997 Labour Government abolished fundholding and introduced primary care groups (PCGs), which will evolve into primary care trusts (PCTs). A key feature is the concept of clinical governance, which, for the first time, requires explicit clinical standards including clinical audit and other quality improvement processes, day-to-day use of evidence-based practice, risk reduction programmes, and processes to recognise and address poor performance.[17]

These changes call into question the viability of primary care's current disposition. Is GPs' independent contractor status compatible with PCTs' efficient management and future development? Clinical governance also implies a new order of explicit accountability for clinical actions. How well equipped are today's 'future general practitioners' to respond creatively to these changes? What extra skills will they need and how will their roles evolve?

- Recruitment is falling in general practice.
- Vocational training does not adequately prepare doctors for contemporary general practice and GPs remain academically disadvantaged compared to hospital doctors.
- PCGs and clinical governance will radically change the nature of primary care.
- Much of current GP work will be done by nurses in the near future.
- Independent contractor status will disappear and doctors in primary care will be salaried.
- 'Community generalists' will need longer training and an extensive range of new skills including evidence-based practice and information management.

Box 1. Keypoints.

'The general practitioner is a doctor who provides personal, primary and continuing medical care to individuals and families. He may attend his patients in their homes, in his consulting-room or sometimes in hospital. He accepts the responsibility for making an initial decision on every problem his patient may present to him, consulting with specialists when he thinks it appropriate to do so. He will usually work in a group with other general practitioners, from premises that are built or modified for the purpose, with the help of paramedical colleagues, adequate secretarial staff and all the equipment which is necessary. Even if he is in single-handed practice, he will work in a team and delegate when necessary. His diagnoses will be composed in physical, psychological and social terms. He will intervene educationally, preventively and therapeutically to pro-

Box 2. General practitioner job description, 1969.[18]

Shifting roles in the primary health care team

Vocational training is based upon a job definition published in 1969[18] (Box 2). The most obvious characteristic of this model is its doctor-centredness. Although team working is mentioned, the GP is assumed to assess every patient's problem before delegating management or referring. A high value is placed on personal care and on the 'triple diagnosis', the diagnosis in 'physical, psychological and social terms'.

Since the early 1970s the primary health care team (PHCT) has expanded exponentially but there is little evidence of true teamwork in most practices. Rather, team members tend to perceive each other in terms of personal relationships and hierarchies and to form small, task-orientated groups for specific purposes.[19,20] Much work is delegated and Marsh describes how general practice can use non-medical staff to become more efficient and relieve GPs of some of their workload.[21] Many studies demonstrate the effectiveness of nurses in managing minor illness,[22] asthma,[23] and telephone triage.[24] Procedures formerly done in secondary care, such as anticoagulation monitoring, have been successfully transferred to the primary care setting[25] without the need for routine GP involvement. New roles are being explored by nurses in primary care; for example, compared with the standard GP-led service a nurse-led minor ear and hearing problem service was as effective in terms of clinical outcomes, more satisfactory to patients, and more cost-effective (including reducing the use of antibiotics).[26]

Baker[27] points out that the trend towards larger and more complicated practices has led to a decline in personal care by GPs, that patients often prefer smaller practices and value being able to consult a doctor they know; he questions whether the future GP 'will still be a personal doctor, or will be a relatively impersonal co-ordinator of care provided by others'. Public demand for access to health care has increased inexorably since the foundation of the NHS, so GPs face a dilemma whether to delegate (which leads to loss of personal care), see more patients (which is counter-productive in terms of quality) or reduce their list sizes to uneconomic levels. Advances in biomedicine continue to increase the proportion of serious and chronic disease that could be treated effectively in primary care, which may imply selective access to doctors. If it is not possible for GPs personally to meet all demands that may be made of them they may need to prioritise and offer personal care only to those who will most benefit.

This conclusion is at variance with the first item in the 1969 GP job description upon which vocational training's philosophy has been based. It would mean that GPs cease to be at the centre of the PHCT, no longer make 'an initial decision on every problem his patient may present to him' but instead see patients referred by other members of the PHCT.

The principle that GPs should make diagnoses in 'physical, psychological and social terms' can also be questioned. Dowrick *et al* found in 1996 that, despite the emphasis on the 'biopsychosocial' approach in vocational training, most GPs believed that biological and, to a lesser extent, psychological matters were appropriate for them to deal with but that social matters, such as housing or spiritual needs, were inappropriate.[28] The 'biopsychosocial' approach itself derives from Balint's work in the 1950s.[29] Sowerby, in an elegant critique, concluded that '[Balint's work] has diverted general practice from its true course … if general practice is to prosper as an independent discipline it must return primarily to a scientific orientation'.[30]

Where do we go from here? Future shock or brave new world?

So what is to be done? The crisis of general practice has not arisen overnight but has been there from the very inception of the NHS;[31] only its nature has changed. It was not caused by the 1990 GP Contract, by fundholding, or by PCGs, which are best seen as attempts to solve contemporaneous problems. The 1969 concept of the 'future general practitioner', and the style of vocational training derived from it, similarly grew out of the problems of the 1950s and 1960s and reflected the need to establish a valid professional role for GPs. This was accomplished with some élan but was a solution for the problems of three or four decades ago, not those of the 21st century. It is clear, too, that

governments expect primary care to make a major contribution to the efficient and effective functioning of the NHS as a whole. What form should primary care take, what should be the role of GPs within it, and what are the educational and organisational needs of GPs and primary care as we move into the 21st century?

Is there a future for the GP at all? Peckham recently speculated that 'we can anticipate the demise of the general practitioner as specialisation enters community medicine'.[32] Although it is arguable that there is indeed no future for the kind of GPs produced by current vocational training, that does not mean that there is no future for generalist doctors in primary care. However, they would need new skills, a different work pattern, and a new career structure.

To function efficiently and effectively in the 21st century, primary care will need to abandon today's 'corner shop' style and management. Financial control of much of the PHCT is currently vested in GPs; this cannot be sustained if they are simply members of the team (albeit highly specialised ones) and no longer at its centre. PCTs will employ most personnel working within them, including doctors, and own or lease most premises. They will provide primary care to populations of 100 000 or more, including 24-hour emergency care, acute illness, chronic disease management, community mental health services, nursing, terminal care, and investigation, treatment, and referral to secondary or tertiary care. Electronic records will be linked between all sites in the trust and patients will be able to access care in any of their surgeries or clinics via the Internet from their homes, or perhaps at terminals in shopping centres.[33] Patients will usually consult nurse practitioners for acute or minor illnesses and will attend nurse- or technician-run clinics for chronic disease management. They will self-refer to physiotherapists, counsellors, and others, perhaps making appointments themselves on the computerised appointment system. Many smaller clinics (the equivalent of present day branch surgeries) will be run by nurses, with telemedicine links to larger clinics. It is likely that the pastoral role traditionally ascribed to GPs will be largely taken over by nurses and this will have the advantage that patients who do not require medical intervention will be empowered to take more control of and responsibility for their own health.

From general practitioner to community generalist

Generalist doctors will be employed within the trust but will have a longer training period than at present, expecting to be appointed to a senior post at about the same age as their colleagues in secondary care. Like general physicians they will primarily be experts in the diagnosis and management of often undifferentiated biomedical problems. Evidence-based medicine will be integral to their clinical method; thus, they will routinely formulate structured answerable questions, search for evidence using computer databases, critically appraise it, and communicate the therapeutic or diagnostic options to the patient (which will, of course, require the excellent communication skills emphasised in vocational training today).[34] The need for this role is already apparent when patients come to the surgery with information from the Internet, which may or may not be valid; the GP needs to critically appraise it and find better evidence if necessary. Developments in technological medicine will accelerate[35] and the 'community generalist' will have a pivotal role as an information specialist capable of identifying and critically appraising which diagnostic tests and therapies are valid and applicable to their patient.[36]

Most GPs today are neither educated nor prepared to undertake this role[37] and, in this narrow sense, Peckham is correct to predict the demise of general practice. There will simply be no place, except in junior positions, for GPs equipped only with today's 'knowledge, skills and attitude'. In the early 1980s, Tudor Hart observed that in the United States nurse practitioners' clinical workload already encompassed a substantial proportion of what GPs did in the United Kingdom.[38] Is it conceivable that PCTs will be willing to pay GPs twice or three times the salary of a nurse practitioner for undertaking a broadly similar clinical workload?

What is required is a radical reshaping of GP education and career structure. At present only about 5% of GPs consider that acquiring the skills of evidence-based practice is the 'route to evidence-based medicine'.[37] The philosophy and methodology of 'life-long self-directed learning' (the basis of evidence-based practice)[34] should be incorporated into doctors' education at medical school and continue throughout higher professional training and professional life until retirement. Doctors who become 'community generalists' should expect to take a higher degree as well as membership of the appropriate college and to be involved in research and teaching.

PCTs will develop an educational and research infrastructure from existing resources such as research practices, teaching and training practices, and primary care research networks. This opens up the exciting possibility that researchers will at last be routinely based in the community, investigate clinical and other questions arising directly from problems in primary care, and have the organisational, educational, and academic means to implement research findings.

Changes of this magnitude represent a major challenge to all involved in primary care. For GPs it implies redefining their clinical role, acquiring new clinical, educational, and academic skills, giving up their independent contractor status, and learning to work as salaried employees of large, professionally managed organisations. Some may perceive this as threatening and many may retire early. The RCGP will have a key role in re-evaluating and re-designing vocational training and may have to discard cherished customs and beliefs. The rewards lie in enhanced opportunities for doctors to practise high quality, personal medicine in the community, with much improved medical care for individual patients. Such doctors will enjoy stimulating, structured careers and be better empowered to fulfil their potential and use their talents for the benefit of their patients.

References

1. Royal College of General Practitioners. *The Future General Practitioner: Learning and Teaching.* London: RCGP, 1972.
2. Taylor DH Jr, Leese B. Recruitment, retention, and time commitment change of general practitioners in England and Wales, 1990-4: a retrospective study. *BMJ* 1997; **314:** 1806-1810.
3. Appleton K, House A, Dowell A. A survey of job satisfaction, sources of stress and psychological symptoms among general practitioners in Leeds. *Br J Gen Pract* 1998; **48:** 1059-1063.
4. Petchey R, Williams J, Baker M. 'Ending up a GP': a qualitative study of junior doctors' perceptions of general practice as a career. *Fam Pract* 1997; **14:** 194-198.
5. Bonsor R, Gibbs T, Woodward R. Vocational training and beyond — listening to voices from a void. *Br J Gen Pract* 1998; **48:** 915-918.
6. Baker M, Williams J, Petchey R. Putting principals back into practice: an evaluation of a re-entry course for vocationally trained doctors. *Br J Gen Pract* 1997; **47:** 819-822.
7. Smith F, Fuller J, Hilton S, Freeman G. The London Academic Training Scheme (LATS): an evaluation. *Fam Pract* 1998; **15(1):** S40-S44.
8. Royal College of General Practitioners. *RCGP Members' Reference Book 1997/98.* London: Campden Publishing Limited, 1997.
9. Kelly MH, Murray TS. Motivation of general practitioners attending postgraduate education. *Br J Gen Pract* 1996; **46:** 353-356.
10. Secretary of State for Health. *Primary Care: Delivering the Future.* London: Department of Health, 1996.
11. Smith LFP. Research general practices: what, who and why? *Br J Gen Pract* 1997; **47:** 83-86.

12. Royal College of General Practitioners. *RCGP Members' Reference Book 1998/99*. London: Campden Publishing Limited, 1998.
13. Swift G. Recollections and reflections: general practice since 1946, the George Swift lecture. *J R Coll Gen Pract* 1982; **32:** 471-479.
14. Irvine DH. Chairman's Report to the Spring General Meeting, Cambridge, March 1985. In: *Quality in Practice: a Bulletin from the Royal College of General Practitioners.* London: RCGP, 1985.
15. Irvine DH. Quality of care in general practice: our outstanding problem. *J R Coll Gen Pract* 1983; **33:** 521-523.
16. Baggot R. Primary Care. In: *Health and Health Care in Britain.* [2nd Edition.] London: Macmillan, 1998.
17. Secretary of State for Health. *The New NHS: Modern, Dependable.* London: The Stationery Office, 1997.
18. Royal College of General Practitioners. The educational needs of the future general practitioner. *J R Coll Gen Pract* 1969; **18:** 358-360.
19. Pearson P, Jones K. The primary health care non-team. [Editorial.] *BMJ* 1994; **309:** 1387-1388.
20. Long S. Primary health care team workshop: team members' perspectives. *J Adv Nurs* 1996; **23:** 935-941.
21. Marsh GN. *Efficient care in general practice.* Oxford: Oxford University Press, 1991.
22. Rees M, Kinnersley P. Nurse-led management of minor illness in a GP surgery. *Nursing Times* 1996; **92:** 32-33.
23. Dickinson J, Hutton S, Atkin A. Implementing the British Thoracic Society guidelines: the effect of a nurse-run asthma clinic on prescribed treatment in an English general practice. *Respir Med* 1998; **92:** 264-267.
24. Jones K, Gilbert P, Little J, Wilkinson K. Nurse triage for house call requests in a Tyneside general practice: patients' views and effect on doctor workload. *Br J Gen Pract* 1998; **48:** 1303-1306.
25. Galloway MJ, Foggin JJ, Dixon S. Introduction of computer assisted control of oral anticoagulation in general practice. *J Clin Pathol* 1995; **48:** 1144-1146.
26. Fall M, Walters S, Read S, *et al.* An evaluation of a nurse-led ear care service in primary care: benefits and costs. *Br J Gen Pract* 1997; **47:** 699-703.
27. Baker R. Will the future GP remain a personal doctor? *Br J Gen Pract* 1997; **47:** 831-834.
28. Dowrick C, May C, Richardson M, Bundred P. The biopsychosocial model of general practice: rhetoric or reality? *Br J Gen Pract* 1996; **46:** 105-107.
29. Balint M. *The Doctor, His Patient and the Illness.* London: Pitman, 1964.
30. Sowerby P. Balint reassessed. The doctor, his patient and the illness: a reappraisal. *J R Coll Gen Pract* 1977; **27:** 583-589.
31. Collings JS. General practice in England today: a reconnaissance. *Lancet* 1950; **1:** 555-585.
32. Peckham M. Future health scenarios and public policy. In: Marinker M, Peckham M (eds). *Clinical Futures.* London: BMJ Books, 1998; 186.
33. Purves IN. Facing future challenges in general practice: a clinical method with computer support. *Fam Pract* 1996; **13:** 536-543.
34. Sackett DL, Richardson WS, Rosenberg W, Haynes RB. *Evidence-based medicine: how to practice and teach EBM.* London: Churchill Livingstone, 1997.
35. Marinker M, Peckham M (eds). *Clinical Futures.* London: BMJ Books, 1998.
36. McColl A, Smith H, White P, Field J. General practitioners' perceptions of the route to evidence-based medicine: a questionnaire survey. *BMJ* 1998; **316:** 361-365.
37. Lipman T. Is there a clinical future for the general practitioner? [Letter.] *BMJ* 1999; **318:** 1420.
38. Hart JT. The world turned upside down: proposals for community-based undergraduate medical training. George Swift Lecture 1985. *J R Coll Gen Pract* 1985; **35:** 63-68.

Address for correspondence

Dr Toby Lipman, Westerhope Medical Group, 377 Stamfordham Road, Westerhope, Newcastle upon Tyne NE5 2LH. E-mail: toby@tobylipm.demon.co.uk